EXHIBIT H

ORIGINAL

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
- -x
ESTATE OF VALERIE YOUNG, by VIOLA YOUNG, as Administratrix of the Estate of Valerie Young, and in her personal capacity, SIDNEY YOUNG, and LORETTA YOUNG LEE,

Plaintiffs,

-against-

STATE OF NEW YORK OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, PETER USCHAKOW, personally and in his official capacity, JAN WILLIAMSON, personally and in her official capacity, SURESH ARYA, personally and in his individual capacity, KATHLEEN FERDINAND, personally and in her official capacity, GLORIA HAYES, personally and in her official capacity, DR. MILOS, personally and in his official capacity;

Defendants.
- -x

350 Fifth Avenue
New York, New York

March 27, 2008
10:25 A.M.

DEPOSITION of JOVAN MILOS, M.D., one of the Defendants in the above-entitled action, held at the above time and place, taken before Gretchen A. Milton, a Shorthand Reporter and Notary Public of the State of New York, pursuant to the Federal Rules of Civil Procedure, Notice and stipulations between Counsel.

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APPEARANCES:

CATAFAGO LAW FIRM, P.C.
Attorneys for Plaintiffs
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New York, New York 10118
BY: JACQUES CATAFAGO, ESQ.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
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BY: JOSE L. VELEZ, ESQ.

JOVAN MILOS, M.D.

A. With the team.

Q. Do you recall anything about the discussion you had with the team about the use of a wheelchair for Valerie Young?

A. The wheelchair was prescribed for Valerie. She had a condition called foot drop.

Q. Foot drop?

A. Foot drop. Yes, she had right foot drop.

MR. VELEZ: I want you to slow down. I want you wait for him to finish the entire question before you answer.

Q. For Valerie Young, was it part of the daily routine that she would go from one building to another building each day?

A. She was in programs so she would leave about 9:00 a.m. and come back at 3:00 p.m., and because of the condition she had developed, foot drop, it was difficult for her to walk from the building where she resided to the building where she had program. So it was agreed

to issue a wheelchair, to give Valerie a wheelchair, to transfer her from one building to the other building.

Q. Who was it prescribed by?

A. It was discussed with the team.

Q. Who made the ultimate decision to put her in a wheelchair?

A. It was the entire team --

Q. Who was the person in charge of the team? Who was the team leader?

A. Kathleen Ferdinand.

Q. Do you specifically recall discussions about a wheelchair for Valerie Young with Kathleen Ferdinand?

A. We discussed it as a team.

Q. How many times did you discuss with the team the use of a wheelchair for Valerie Young?

A. I don't remember.

Q. Did you ever discuss anything else with Kathleen Ferdinand, other than the wheelchair, relating to Valerie Young?

A. We had team meetings about Valerie.

mobility needs?

A. I don't know that. I do not know.

Q. Was it more than one wheelchair?

A. I do not know that.

Q. Did you ever personally observe anyone providing physical therapy to Valerie Young after April 20, 2005?

A. Physical therapy was provided by the physical therapy department.

Q. Did you see anyone --

A. I do not go there.

Q. Did anyone ever tell you or show you any document that reflected that she was receiving any physical therapy at all at any time after April 20, 2005?

A. It should be there.

Q. I am asking if you --

A. I did not know that.

MR. VELEZ: Counsel, please let him finish the answer.

MR. CATAFAGO: He did.

MR. VELEZ: Did you finish?

THE WITNESS: I don't know what

status in the three months before her death?

A. She was stable, yes, stable for Valerie Young.

Q. You also wrote that there was no agitation, no SIB, or aggression observed.

What is "SIB"?

A. Self-injurious behavior.

Q. Was that accurate when you wrote that?

A. It was accurate.

Q. You also wrote in the column below that, referring to the decedent, that she utilized a wheelchair for transportation to and from program and ambulated with assistance in the residential unit?

A. Yes.

Q. What did you mean by: "Ambulated with assistance in the residential unit"?

A. I meant she was helped by staff.

Q. She would walk with the staff?

A. Yes.

Q. How many times did you see her do

that?

A. When I was making rounds in the morning and in the afternoon, I saw, on several occasions, her doing that.

Q. On April 20, 2005, the special case conference that you attended and signed off on indicated a recommendation that she use a wheelchair for all mobility.

MR. VELEZ: Where are you referring to?

MR. CATAFAGO: I am looking at Exhibit 5.

Q. For all mobility needs, and I'm quoting directly from the second page of Exhibit 5.

Do you see that?

A. Yes.

Q. What was the intent there with respect to all mobility needs? What is intended by that term?

A. My interpretation of that is it is to be used just for transfer from, for transfer from building to building.

Q. What is this document?

A. That's a referral for physical therapy.

Q. Is this a referral for physical therapy that you prescribed for Valerie Young; right?

A. Yes. And also a request for the ankle/foot orthosis.

Q. Is this a request for physical therapy that you handwrote; right?

A. Yes.

Q. So the top part of the document bears your handwriting and is signed --

A. Yes.

Q. What is the date of that handwriting?

A. April 27th.

Q. Year?

A. 2005.

Q. What did you write under: "Present Medical Concerns"?

A. Left foot drop. Please evaluate for physical therapy, range of motion, to prevent fixed constrictures. Also

evaluate for splinting.

Q. What happened after you gave this referral?

A. Valerie Young was seen by the physical therapy department. They did the evaluation and enclosed recommendations.

Q. What were the recommendations?

A. That Ms. Young be scheduled for physical therapy two times per week, to receive mat exercises, ambulation exercise, range of motion exercises to both upper and lower extremities.

Ms. Young will be scheduled to see orthopedist on his next visit to BDC for evaluation of left foot orthosis follow-up.

Q. About six weeks before she passed away, as noted in the report, the physical therapist scheduled Ms. Young for physical therapy treatments twice a week?

A. Yes.

Q. Do you know if that occurred?

A. There is no reason to believe it did not occur.

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Brooklyn Developmental Disabilities Service Office

ANNUAL CFA TEAM MEETING DISCUSSION

I. Identifying Information

Consumer's Name: Valerie Young **Date of Meeting: 4-13-05**
D.O.B. 8-6-55 **Gender: female**

Diagnosis:

Axis I schizoaffective disorder/intermittent explosive disorder
Axis II profound mental retardation
Axis III constipation, seizure disorder, mild EPS

Unit: 3-1 **Wing: 314**

Legal Guardianship: Mrs. Young, Valerie's mother, is interested in seeking legal guardianship of her daughter and is in the process of filing the papers.

II. Physical Development & Health Status

Any significant medical findings

Valerie is a 49 year old ambulatory (but with left foot drop and high steppage gait), verbal woman who functions within the profound range of mental retardation. She has a history of seizure disorder, which is well controlled with Topamax (see also special meeting minutes 5/6). She sees the neurologist yearly or as needed. Valerie also suffers from constipation (h/o severe impaction) and she receives Metamucil, Colace and a Fleet enema three times per week. Her diet is also high in fiber and extra fluids are encouraged in order to aid the BM. Valerie had a mammogram attempted 3/05 and was uncooperative. Manual breast exams continue to be a part of her yearly physical.

Valerie's psychotropic medications have changed over the year, and she continues to exhibit mild EPS (however improved in comparison to previous years). When Valerie is sedated or unsteady on her feet, the team agrees for a wheelchair to be utilized (and also for longer distance transportation). Overall Valerie has been more alert and psychiatrically stable the past few months. See psychiatric findings for more info on the psychotropic medication regimen.

The team agrees that Valerie should receive a small dose of medicine for sedation/ calming prior to clinic visits upon the physician's discretion. BMRC approved the use of pre-sedation on 11-7-04 and informed consent was given on 12-30-04.

Current Health Status

Valerie's health status is currently stable (primary concern is behavior status and psychotropic medication regimen). Current medications: Topamax 100mg BID,

Remeron 45mg HS, Inderal 80mg TID, Tegretol 400mg/am, 400mg/pm and 400mg/hs, Prevacid 15mg hs, Colace 200mg hs, Metamucil 2tsp QOD/hs; Zyprexa 20mg BID, Klonopin .5mg hs and Fleet enema 3x/wk per rectum.

The team reviewed Valerie's pharmacy evaluation and agree to the following recommendations: monitor BM, suggest bulk laxative-Metamucil on order, monitor drowsiness, EPS and check baseline EKG and fasting blood sugar every 2-3 months. All recommendations being carried out as appropriate. The team agrees that although Valerie exhibits some drowsiness in the morning hours, it is still a marked improvement from past observations where it occurred throughout the day. EPS is mild at this time.

Serious Illnesses/Injuries/Hospitalization during the past year.
On 11-3-04, upon return from program, Valerie was observed with her 2nd and 3rd digits of her left hand swollen and discolored. She was sent out for evaluation to rule out fracture, which was negative. Valerie was diagnosed with a soft tissue contusion and the fingers were wrapped up. The physician stated that she will be re-evaluated as needed. Staff reported that Valerie swings her hands (possibly that's how she sustained the injury?) and the psychologist placed a baseline in for that behavior. That behavior is now being tracked in her plan for disruption. Valerie was also placed on 15 minute checks. No further incidents with hand swinging have been noted.

Allergies
Nevane and Haldol caused EPS, Depakote caused elevated Amylase level

Sleep Habits (include special needs, i.e., bedrails, oxygen, etc.)
Has bouts of insomnia over the year; Medication for sleep and to aid nighttime agitation is on order. The team reviewed the evening and nighttime logs and note that Valerie is up at night fairly often. However, she is calm during these times and not engaging in disruptive behaviors (which is an improvement as well). This could contribute to the am grogginess that has been noted. The physician recommended changing her Zyprexa evening dose to HS in order to further aid nighttime sleep. The team agreed to the recommendation.

Dental findings
On 5-11-04 and 12-22-04 Valerie had tooth extractions done without complication. As per dental exam on 9-28-04: Valerie has non-inflamed soft tissue, restored teeth, missing teeth, decalcification and periodontitis advanced. Valerie is very uncooperative during exams and requires sedation prior to treatment (BMRC/informed consent rec'd). She lacks the cognitive ability to wear dentures. Valerie's oral hygiene is noted to be poor and therefore the team recommends the continuance of the oral hygiene goal to address the need.

Any significant psychiatric findings
Valerie has a diagnosis of schizoaffective disorder/intermittent explosive disorder including severe behavior problems of agitation, aggression, assault, property

destruction, disruption and non compliance. Valerie went through several periods of behavioral instability with medication changes and psychiatric hospitalizations over the past year. The following is a summation of all occurrences since her last annual:

During the first quarter, Valerie's behavior had been unmanageable; agitated, highly aggressive and assaultive. Valerie began treatment with Dr. Hahn (BDC psychiatrist/neurologist) and no longer sees Dr. Coste from Maimoneddes (see special case conference 5/6). Several ITT meetings (5/12, 5/24, 5/26) were held to address Valerie's behavioral instability and proposed medication changes. Valerie had to be placed on 1:1 during this extremely unstable period. She was placed on a new medication regimen of Zyprexa, Trilofan, Seroquel, Neurontin and Trazodone. She was referred to her psychiatrist 7/14 for evaluation of her current medication regimen due to falling/unsteadiness on her feet. The falling/unsteadiness can be a side effect (akatesia-EPS) of Trilofan and the psychiatrist recommended a decrease from 32mg to 24mg daily. (see also consultation) Ambien 10mg HS was also added to her medication regimen to aid sleep A standing PRN dosage of psychotropic medication was on order if Valerie was up between the hours of midnight and 4am. At her first quarterly review 7-20-04, Valerie's medications consisted of Zyprexa 15mg am and hs; Ambien 10mg hs; Trilofan 8mg/6am, 8mg/10am, 8mg/1pm; Seroquel 200mg QID, Neurontin 900mg QID, Trazodone 150mg am, pm and hs plus 100mg PRN between midnight-4am.

The team noted at the first quarterly meeting that Valerie has made some improvement in behavior, since she had not been aggressive or assaultive. However, she continued to be awake at night, running around, hyperactive, pulling down curtains. Valerie has some good and bad days; more alert and responsive one day, agitated and hyperactive the next. Since the over-hyperactivity is not on a consistent basis, the team agreed with the psychiatrist's recommendation to add a standing PRN dose of Zyprexa IM for those particular days. Valerie has also been walking leaning forward and had several incidents of falling. In an effort to combat the side effects (ataxia, etc), the psychiatrist recommended to reduce Trilofan. (Cogentin was also discontinued in an effort to reduce risk of constipation.) We referred to BMRC for approval for the PRN order of Zyprexa, but it was denied.

Valerie was sent out to Coney Island hospital psychiatric unit on 8-10-04 for continued unmanageable physical aggression, agitation and destructive behavior. She returned 8-23-04 on the following medications: Remeron 45mg, Inderal 240mg and Clozapine 87.5mg daily. Upon her return the team recommended to continue the medication regimen that the hospital instituted. On 9-17-04 Valerie was observed oversedated, sleeping most of the time. She was referred to the psychiatrist for a re-evaluation of her medication regimen. Remeron was decreased to 30mg HS as of 9-17-04. At the time of her 2nd quarterly review 10-13-04, Valerie was receiving Clozapine 25mg/am, 62.5mg/hs; Remeron 30mg HS; Inderal 80mg TID.

Valerie exhibited unmanageable behavior over the third quarter. Ativan 2mg im stat was given on 10-20-04 for agitated and aggressive behavior. On 10-22-04 her Remeron was increased to 45mg and on 11-10-04 Clozaril was increased to 100mg daily due to

increased noncompliance, aggressive behavior. She was evaluated again by the psychiatrist on 11-30-04 who observed her to be extremely agitated, disruptive, turning over furniture, running around the wing and attacking others. Ativan 2mg IM stat was given.

Valerie was sent out to the Psych ER at Kings County hospital on 12-1-04 because of extreme behavior instability: wildly psychotic, stripping, attacking others, turning over furniture and tearing curtains. She remained there until 12-13-04. While at the hospital, Clozapine was discontinued and replaced with Zyprexa 20mg BID due to leucopenia. She was discharged back to the facility on Inderal 240mg, Remeron 45mg, Tegretol 1200mg and those medications were reordered and continued.

On 12-21-04 Valerie was being dressed by staff and became agitated. She pulled away from the staff and fell onto another consumer's bedrail. She sustained a laceration on her lower lip, small laceration on the chin and abrasion on the left inpraorbital area. (Also noted was two loose lower incisors) She was referred to the dentist who performed the suturing of the wound. The team agreed to have Valerie re-evaluated by both psychiatrists Dr. Delbrune and Dr. Hahn since Valerie is still not stable, extremely agitated and destructive (yelling, banging, running). She is also not sleeping at night. They will be asked to consult together and give conjoint recommendations for a psychotropic medication regimen. Dr. Hahn was unavailable for consult and Dr. Delbrune re-evaluated Valerie and recommended to add Klonepin in addition to her present medications. Due to the extreme nature of Valerie's outbursts, the team agrees that we cannot wait for the conjoint consult as previously recommended. We will refer to BMRC for Klonepin with a range from 3-6mg and if there is no improvement, then the joint consultation will be requested again. The team agrees to continue the medication regimen instituted by Kings County, (current dosages are Remeron 45mg, Inderal 80mg TID, Tegertol 400mg TID, Zyprexa 20mg BID) in addition to Klonopin .5mg HS to aid sleep.

Psychotropic medication review (include changes over the past year and rationale)
See above

Recommendation for reduction in medication. If none is recommended, explain.
No reduction at this time; The team agrees to continue current medication regimen since she has not been stable for a sufficient length of time. (She has a history of cyclical behavior changes) In addition, Valerie went through many medication changes in order to stabilize her over the year. Now that she is calmer, her medication regimen should remain constant.

Discuss consumer's ability to self administer medication.
Valerie was assessed by the nurse for her potential to self administer medication. Valerie exhibits the ability (with verbal prompts) to respond to the person giving out the medication, can open mouth to have medication placed within, swallow

liquid/solid form of medication and can drink water from a cup to accompany the medicaiton. The nurse indicates that Valerie is now capable to work on holding med cup/glass steady while pills/water are put in. The team agreed to the assessment. Valerie's response and cooperation can be inconsistent depending upon behavioral status. She continues to be encouraged to participate to the best of her ability.

Team Recommendations:

Age appropriate preventative medical and supportive care, regular psychiatric and neurological follow up, annual optometric and audiological screening and monitoring for potential adverse effects of psychotropic/neuroleptic medications. Wheelchair for mobility as needed and for longer distance transportation.

III. **Nutrition:**

Review of assessment. Include current diet, rationale and any special dietary needs. Include discussion of any significant weight gain/loss.

Valerie has been receiving a chopped hi fiber high calorie diet with prune juice 8oz with breakfast and dinner, 2tb bran with breakfast and extra fluids. March '05 weight is 148 lbs. which reflects overall stable weight maintenance over the year (weight has fluctuated 142-148 pounds during this time). Fluctuations could be due to psychotropic medication changes. A significant weight loss of 12 pounds was exhibited in August, however it was a possible scale error. Even though Valerie is above her IBW of 125-135 lbs., the dietician does not recommend any changes since Valerie can lose weight easily (becomes very hyper). If significant weight gain occurs, the team will re-evaluate. Valerie has an average to good appetite and completes most of her meals. Her self feeding skills vary depending upon behavioral status. Valerie utilizes a built up handle teflon coated spoon and high sided dish with non slip pad to aid dining skills. Walking in the evening time should be encouraged to aid weight loss; however it is difficult to execute during times of uncooperative/unmanageable behavior.

Team Recommendations:

Continue present diet and monitor weight closely. Choking precautions. Encourage exercises as tolerated.

IV. **Sensory/Motor:**

Review of assessment. Include program, recreation, O.T./P.T. (if indicated) audiological, and eye exam.

Valerie is a verbal, ambulatory (with left foot drop and high steppage gait) woman who has full range of motion in upper and lower extremities. She can make brief eye contact and focus on an object. Valerie is fully sighted and her hearing is within normal limits. Valerie had an audiogram on 5-17-04. Speech awareness or localization was present within normal conversational limits and middle ear function within normal limits. Annual audiogram is recommended. . As of optometry screening 2-2-04, early cataracts were noted and referral to retina clinic was recommended. Valerie kept a follow up appointment at CIH eye clinic on 2-28-05. Posterior vitrous detachment of the left eye was noted. Poor cooperation made the exam very limited. She will be referred back again for follow up. Valerie has good gross motor and fair fine motor skills. She can participate in

sensory motor recreation activities (beanbag toss, adaptive bowling, etc) with physical assistance, encouragement and guidance (behavior status also has an impact on her level of participation). The team agrees that Valerie continues to require sensory skills training, especially in the area of tactile exploration. Over the year, Valerie has been working on a goal to attend to sensory stimulation activities for five minutes with physical prompts. Valerie has exhibited slow progression due to her hospitalizations and behavior unmanageability, but attained the objective 12/04. She is now working on increasing the time span to six minutes, which the team agrees to continue. This not only serves to improve sensory skills, but also aids in improving attention span. She should also be encouraged to interact in a positive manner with her peers.

Discuss use/need for any orthotic or prosthetic devices. Discuss significant changes over the past year.

N/A

Discuss progress/maintenance/ regression of skills during the past year. Explain any changes.

Valerie's progression in her sensory stimulation objective has been slow due to several hospitalizations and behavior instability over the year. However, some progress is noted since she attained the LRO 12/04.

Team Recommendations:

Continue participation in daily recreation sensory motor activities. Continue objective for Valerie to attend to sensory stimulation activities for six minutes, further challenging her to attend for seven minutes upon its attainment.

V. <u>Cognitive:</u>

Review of assessment. Discuss progress/maintenance/regression of skills during the past year. Explain any changes.

The team agrees that Valerie's functional level is at the pre-attending phase and any further development of her attending skills are depending on prerequisite tasks, i.e. sensory skills. She can identify a few common objects and knows their usage and likes to looks at pictures in books briefly. Valerie continues to respond to her name when called by turning her head towards the caller. She can locate areas in her living and program area with total supervision and physical guidance. Valerie shows some awareness of cause and effect by turning on/off a light switch inconsistently. During the past year, Valerie has been working on pre-attending skills by attending to sensory stimulation activities for five minutes. Valerie has shown slow progression in her objectives due to several hospitalizations and unmanageable behavior, which distracts her from the task at hand. Progress has been noted over the third quarter, when she attained the LRO 12/04. She has now moved onto increasing the time span to six minutes. When Valerie has successfully attained this objective, she will further be challenged to increase the time span to seven minutes. Over the year, Valerie has been introduced to pre-requisite skills in money management through a goal to glance at an item, then participating in its purchase (given physical prompts). The team agrees to continue the goal, moving onto gestural prompts upon attainment.

Team Recommendations:

Continue program objectives to attend to sensory stimulation tasks for 6 minutes, increasing the time span to seven minutes upon attainment. Continue purchasing goal, moving to gestural prompting upon attainment.

VI. Social:

Review of social assessments (Include social work and recreation and leisure) Also discuss impact of psychiatric diagnosis on social interaction skills.

Valerie is a 49 year old verbal woman who functions at the profound range of mental retardation and ambulates independently. Valerie verbalizes in 1-4 words and is capable of establishing/maintaining eye contact with familiar staff. Valerie is capable of following simple directions/requests. She is aware of her surroundings and enjoys visits from her mother very much. She can even answer questions about her mother such as "is ma here?" with an answer like "ma not here". Valerie engages in aggression, disruption and non-compliance, which often interferes with her socialization and group participation skills. All socialization activities require staff initiation and implementation. The team recommends continuing daily recreation activities to improve her socialization skills. Valerie should also be encouraged to interact with her peers as independently as possible, giving verbal praise for all positive interactions. Valerie's current socialization goal to participate in three group activities given 2vp will continue as well.

Discuss community inclusion activities and consumer's response-

Valerie has attended various trips with her classmates/roommates over the year: Brooklyn Terminal Market, Sheepshead Bay, Gateway mall and Canarsie pier, Coney Island boardwalk (and others). Valerie requires close supervision during outings since she may engage in aggressive behavior. During those times, her behavior plan is implemented.

Family involvement/issues –

Mrs Viola Young, Valerie's mother, is her correspondent. Mrs. Young is very involved in Valerie's life; she visits often, attends all service plan and special meetings and attends all clinic visits with her daughter.

Placement efforts/issues –

Valerie has not been screened during the year. She exhibits unmanageable behavior in the form of aggression, non compliance and disruption which prevents her from moving to a less restrictive setting at this time. (See also behavior management section) However, the social worker continues to work with Valerie's family regarding future potential residential placement opportunities, as they become available.

Discuss progress/maintenance/regression of skills during the past year Explain any changes.

Valerie's progression in her socialization objective has been slow due to several hospitalizations and unmanageable behaviors. However, recent progress is noted by her attainment of socialization goal 3/05.

Team Recommendations

Provide encouragement so that Valerie participates in socialization activities with her peers during daily recreation. Continue program objective to participate in 3 group activities given 2 physical prompts. Upon attainment, Valerie will have the skills needed to work on participating in 3 group activities given an initial verbal cue. Continue to provide Valerie's mother with information regarding community placements for Valerie (when she is ready) as opportunities become available.

VII. Affective Emotional:

Review psychological assessment. Discuss progress/maintenance/regression over the year (in behavior goals and counseling sessions). Explain any changes.

Valerie functions within the profound range of mental retardation. She is diagnosed with schizoaffective disorder/intermittent explosive disorder. Valerie's behavior management program consists of behavior interventions for aggression, disruption and non-compliance and an extensive psychotropic medication regimen. Frustration, discomfort and overall uncooperativeness to all tasks may be an antecedent to escalated, severe behavior problems. At times of unmanageability, Valerie can pose a danger to herself and others. As outlined in the psychiatric section, Valerie has gone through two psychiatric hospitalizations, various medication changes and some cyclic behavior changes. Lately, Valerie has made progress in behavior management, but has not remained stable for a sufficient length of time. Therefore, her present medication regimen should continue. Due to Valerie's level of functioning, she is not a candidate for counseling or stress management.

As a result of the investigation of the 11/3 incident (Valerie was sent out for evaluation of swollen fingers), the following recommendations were made and discussed by the team. Valerie has a contact book which should continue, with paying close attention to the fingers, especially after she has been agitated (engages in hand banging/swinging). The psychologist noted that Valerie's behavior plan for destruction which includes the target behavior of banging hands was revised and now reads banging/waving hands as a result of the 11-3-04 incident (refer to special meeting minutes 11/5). When the routine body checks are done, staff should also pay attention to the integrity of her hands. Another recommendation has been made for Valerie to continue working on her program objectives which provide alternative activities involving functional and appropriate use of her hands, i.e. attending to sensory stimulation activities for 5 minutes, developing oral hygiene and hand washing skills. The program head up has providedinformation as to what kinds of activities Valerie enjoys in program, so that they can be ordered for her residential unit. The possibility of posey mitts was then explored by the team. The team feels that the posey mitts will further agitate Valerie and she may injure herself in an attempt to remove the mitts (she will most likely be successful in removing them as well). {It is also noted that when Valerie is in a severe state of agitation, placing any type of adaptive apparel on her is nearly impossible.}

Discuss:

Ability to give informed consent for medication.

Due to deficits in cognitive skills, Valerie is unable to comprehend the risks and

benefits involved and therefore cannot give consent for medication. Valerie's mother, acts in that capacity for her.

Ability to give informed consent for sexual issues
Valerie was assessed in the area of sexuality and is deemed unable to thwart unwanted sexual advances, nor does she understand the rights of others or precautionary measures.

Ability to have a grounds pass.
Valerie is not a candidate for a grounds pass at this time. She has always required staff supervision at all times when traveling. Even though she is aware of her residential and classroom environment, Valerie does not exhibit the cognitive ability to tour the grounds independently. Behavioral instability also prevents Valerie from having free access. The ITT had determined that as a result of profound cognitive deficits, and the inability to recognize dangerous situations/persons in combination with the inability to self preserve beyond a supervised and secure perimeter, Valerie should *only* have access with staff supervision.

Ability to maintain a key to wardrobe.
Due to severe deficits in her cognitive skills, she is not capable of maintaining a key to her closet.

Ability to participate in voting.
Due to severe cognitive she is not capable of participating in the voting process.

Discuss forensic issues – any changes over the past year.
N/A

Include discussion of any special counseling needs (i.e., substance abuse, sexuality, etc.)
N/A

Team Recommendations
Continue behavior interventions for aggression, disruption and non-compliance. Implement psychotropic medication as outlined by physician and psychiatrists.

VIII. <u>Communication:</u>

Review assessment (Speech and Language/Audiological). Include discussion on expressive and receptive language skills.
The team agrees that Valerie can verbalize greetings, single words and simple phrases. She can inconsistently indicate a need when questioned. Valerie is aware of her surroundings and can localize to sounds and familiar voices. Available audiological information 5-17-04 states that Valerie has speech awareness or localization present within normal conversational limits and middle ear function within normal limits. However, she continues to express phrases regarding her mother "ma here" and to indicate rejection "don't wanna go". We will continue to encourage Valerie to vocalize, as appropriate, during all activities. The team agrees that speech services are not warranted at this time.

Discuss any alternative communication skills (i.e., sign language/total communication, augmentative devices, body language, etc.).
N/A

Discuss progress/maintenance/regression of skills during the past year. Explain any changes.
Verbalizations can be inconsistent. However, generally, Valerie has maintained her present level of communication skills over the past year.

Team Recommendations:
Speech/language services are not indicated at this time. We will continue to encourage Valerie to verbalize appropriately.

IX. **Adaptive/Independent Living Skills:**

Review assessment. Discuss progress/maintenance/regression of skills during the past year. Explain any changes.
Valerie requires prompting and assistance during all activities of daily living. Valerie does not consistently hold her spoon for feeding. She has been working on an objective to hold her spoon through five spoonfuls of food given hand over hand prompting, which was attained 11/04. She has now moved onto six spoonfuls. The team agrees that this continues to be a need and it will continue. When that is successfully attained, Valerie will be challenged to increase it to seven spoonfuls. Valerie has been working on a goal to reach for the towel presented to her after washing her hands given 3 physical prompts at the wrist. The team agrees that personal hygiene continues to be a need, therefore the revised goal for hand drying with pp at the elbow will continue. Since Valerie is noted to have poor oral hygiene, a formal goal for toothbrushing is being implemented. The team agrees to continue the objective, moving from hand over hand prompts to prompts at the wrist upon attainment. Valerie's level of participation in activities and success in her goals is contingent upon her behavior management, which is being monitored closely. The team also notes that Valerie has demonstrated slow progression in her objectives because of hospitalizations and behavior instability she had exhibited over the year. However, progress has been noted in the past couple of months, as demonstrated by the attainment of long range objectives.

Discuss impact of development of these skills on community integration.
It is important for Valerie to develop these skills so that she would better function in a less restrictive living environment. Due to her cognitive limitations, Valerie will always require staff supervision/verbal prompts during all activities of daily living. Valerie is also developing skills in other domains, cognitive-attention to task, socialization, and behavior management, which would help her get ready for movement into the community. The team notes, however, that because Valerie has not been psychiatrically stable for a sufficient length of time, movement into the community is not recommended at this time.

Team Recommendations:
Continue dining objective for Valerie to hold her spoon through six spoonfuls,

increasing to seven spoonfuls upon attainment. Continue hygiene objective for reaching for a towel that is presented to her after washing her hands. Continue toothbrushing goal, moving from hand over hand prompts to prompts to the wrist upon attainment. All goals are implemented with physical prompts.

X. **Vocational Skills:**

Review assessment. Discuss any changes in program placement.

Valerie attends BDC's Activities Therapy Program in Building 5. The team agrees that Valerie's attention span is limited and she is being encouraged to participate in pre-attending skills of sensory stimulation. Further development of her attending skills are depending upon prerequisite tasks. The team agrees that Valerie should continue with the services previously stated in this assessment, since they serve to address pre-vocational needs that coincide with her abilities at this time. Valerie will continually be encouraged to engage in prerequisite skills training in sensory stimulation, activities of daily living skills, appropriate socialization and behavior management.

Discuss progress/maintenance/regression of skills during the past year. Explain any changes.

Valerie functions primarily at the pre-attending level and formal vocational training is beyond her capabilities at this time. She has shown slow progression in her objectives due to hospitalizations and behavior instability.

Team Recommendations: Continue participation in ATP program. Continue prerequisite skills training in the sensory-motor, ADL, behavior management, cognitive and socialization domains.

Annual IPP Prepared by: _____
Dawn Marie Pizzonia, client coordinator, HS1

Date prepared: 4-13-05

Approved by: _____ Team Leader (QMRP)

NEEDS/PROBLEMS LIST

Need & Issue	How the issue is being addressed	Priority Level	Method
PHYSICAL DEVELOPMENT & HEALTH STATUS (Medical, Nursing, etc.)			
To maintain good control of seizure disorder	Medication as ordered Neurological follow-up Monitor for seizure activity and treat as necessary	High	Routine ongoing service
Potential for constipation	Medication as ordered Special high fiber dietary component Monitor for constipation and treat accordingly	High	Routine ongoing service
To improve poor oral hygiene	Routine dental care and daily toothbrushing Implement toothbrushing goal	High	Routine ongoing service Formal goal plan for toothbrushing
To maintain overall good general health	Keep all clinic appointments Health status monitored routinely by medical staff	High	Routine ongoing service
To develop pre-requisite self-med skills	Valerie will swallow her medications with applesauce	High	Self-med goal
NUTRITIONAL STATUS			
To maintain weight within her desired body weight range	Special high calorie diet as recommended Monthly weight monitoring	High	Routine ongoing service
Potential for choking	chopped consistency diet	High	Routine ongoing service
Potential for Constipation	High fiber dietary component as ordered Medication as ordered	High	Routine ongoing service
To aid dining skills	Built up handle, teflon coated spoon, high sided dish and non slip pad	High	Routine ongoing service
SENSORY MOTOR DEVELOPMENT			
To enhance her Sensory skills	Valerie will attend to sensory tasks for 6 minutes	High	Priority objective #2 currently ongoing
COGNITIVE SKILL DEVELOPMENT			
To enhance her attention span	Valerie will attend to sensory tasks for 6 minutes	High	Priority objective #2 currently ongoing
Improve/maintain sensory motor skills	Valerie will participate in daily recreation sensory motor activities.	High	Routine ongoing service
To develop pre-requisite money management skills	After glancing at a chosen item, Valerie will participate in its purchase given pp	High	Priority objective # Move to gp upon att
SOCIAL DEVELOPMENT			
To improve peer interaction skills	Valerie will participate in 3 group activities given 2 physical prompts	High	Priority objective #3 currently ongoing and reinforced residentially
To improve/maintain current level of socialization	Participate in socialization activities during daily	High	Routine ongoing service

skills	recreation		
AFFECTIVE/EMOTIONAL DEVELOPMENT			
To eliminate aggressive behavior	Implement behavior intervention for aggression Medication as ordered Regular Psychiatric f/u	High	Priority objective #6 currently ongoing and reinforced residentially
To eliminate disruptive behavior	Implement behavior intervention for disruption Medication as ordered Regular Psychiatric f/u	High	Priority objective #10 currently ongoing and reinforced residentially
To eliminate non-compliant behavior	Implement behavior intervention for non-compliance Medication as ordered Regular Psychiatric f/u	High	Priority objective #7 currently ongoing and reinforced residentially
COMMUNICATION DEVELOPMENT			
To maintain current level of Communication skills	Participate in daily program, being encouraged to express herself whenever appropriate	High	ATP program Routine ongoing service
ADAPTIVE/INDEPENDENT LIVING SKILLS			
To improve personal hygiene.	Valerie will reach for a towel after washing her hands given pp	High	Priority objective #5 currently ongoing and reinforced residentially
To improve dining skills	Valerie will hold her spoon through six spoonfuls given physical prompting	High	Priority objective #9 currently ongoing and reinforced residentially
To maintain involvement in community activities	Will attend community outings with her peers	High	Routine ongoing service
To improve oral hygiene	Will brush her teeth given hand over hand prompts	High	Priority objective currently ongoing and reinforced residentially move to pp at wrist upon att
VOCATIONAL DEVELOPMENT			
To develop prerequisite vocational skills	Will attend activities therapy program, focusing on prerequisite skills development in the social, sensory, cognitive, and ADL domains	High	Routine ongoing service

BDC-1-NS-MED
REV 10/03

BROOKLYN DEVELOPMENTAL CENTER

ANNUAL NURSING SUMMARY

Consumer's Name Valarie Young C# 098-0032 Annual Date 3/30/05
D.O.B. 8/6/55 Sex: _____

Hepatitis Status IMMUNE TB Status Positive Date 1989
Allergies: NAYANE, HALDOL + Debakate

List of Current Medications: Topamax 100mg BID
LINDBRAL 80mg TID
Tegretol 400mg, 400mg HS
Depakote 250mg PO BID
Haldol 0.5mg QHS
Benadryl 15mg QHS
Celebrex 200mg HS
Ramipril 45mg PO HS
Metformin 2TSF QOD

Showing Side Effects ☒ No ☐ Yes
Describe: Hi Calorie + Hi Fiber NONE
Diet: Hi Calorie + Hi Fiber ground
Communication: ☐ Verbal ☐ Non verbal ☐ Other _____
Vision: ☒ Normal ☐ Impaired ☐ Glasses ☐ Blind Comments _____

Hearing: ☒ Normal ☐ Impaired ☐ Hearing Aid ☐ Deaf Comments _____

Mobility: ☒ Ambulatory ☐ Wheelchair ☐ Special Equipment (list) _____

Physical Aids :(Shoes, Braces, etc.) None
Protective Aids: (Helmet, mittens, etc.) None
Self Administration of Medication:
☐ Independent ☐ With Supervision ☒ With Assistance ☐ Total Support
Progress on Self Medication Program: _____

Current Self Medication Goal: Working task #7 which is to hold glass steady while water poured into it.

PHYSICAL ASSESSMENT

Temperature 98.2 Pulse 72/M Respiration 16/M Blood Pressure 130/80
Height 5F 4½ Weight 157 lbs Gain/Loss Gain
Skin condition: Normal

Respiratory Condition: Normal
Metabolic Condition: Normal
Skeletal Condition (Scoliosis) Normal
Eye: Normal
G.I. Issues: H/O Constipation

BDC-1-NS-MED
REV 10/03

GYN:

Menstruation: ☐ Regular ☐ Irregular ☒ None ☐ Dysmenorrhea
Comment:

Neurological Disorder: (If seizures, type and frequency) Well controlled.

Other Health Problems since last assessment(illness, injury, hospitalization, procedures)

Listed on other sheet.

Personal Hygiene: (Check appropriate column)

	Good	Needs Improvement	Poor
Oral Hygiene		✓	
Bathing			
Toileting			
Hair Care			
Nail/Foot Care			

List any issues/problems (i.e., non-compliance affecting treatment)

None.

Skeletal Condition (Scoliosis)
Eye:
G.I. Issues:
Neurological Disorder: (If seizures, type and frequency) Well controlled.

Other Health Problems since last assessment (illness, injury, hospitalization, procedures)

1/7/05. Attended GYN clinic and evaluated.
1/12/05. Started on Klonopin 0.5mg P.O. HS.
1/25/05. Sustained abrasion to mouth lower lip. No treatment ordered.
1/28/05. Seen by Podiatrist. Nail debridement done.
Fleet enema was given for distended stomach with good effects.
2/13/05 Referred for Annual eye exam. Seen by Opthalmologist and to return in 2 weeks.
3/9/05. Finger stick BB BS was 68mg/dl.
3/20/05. Placed on Sudafed 2TSF P.O TID x3 days for cold symptoms.
3/22/05. Sustained abrasion on left upper eye lid. Same Cleansed/Treated.
3/27/05. Placed on Sudafed for cold symptoms. Extra fluids encouraged. Cond cleared Well
3/28/05. Started on Zithromax for URI started. Cond resolved Well.
Present weight is 151lbs.

List any issues/problems (i.e., non-compliance affecting treatment) None.

Signature of Nurse Completing Assessment — 3/30/05 Date

Signature of Nurse Reviewing Assessment (If Applicable) — Date

Self-administration of medication Assessment

Consumer's Name: Valerie Young Month/Year: 3/30/05

Evaluate the individual's ability to participate in tasks associated with a self-medication program, indicating how independently the consumer typically performs each activity.

Task	Indepen-dently	Verbal prompts	Gestural Prompts	Physical prompts	Unable to perform
1. responds to person giving medication		✓			
2. Opens mouth to have medication placed within		✓			
3. Swallows liquid form of medication		✓			
4. Swallows solid medication (e.g. pill, tablet or capsule) with liquid		✓			
5. Drinks water from glass while holding it		✓			
6. Holds a med. cup containing medication					✓
7. Holds a med. cup/glass steady while pills or water are put in		✓		✓	
8. Pours water into a glass					✓
9. Opens blister pack/bottle and places/pours medication in a med. cup					✓
10. Identifies own name on medication container.					✓
11. Identifies names of medication(s)					✓
12. Identifies time to take medication					✓
13. Communicates dosage of medication					✓
14. Communicates reason and purpose for which medication is being taken					✓
15. Communicates side effects of medication					

1. **Independently** means that the consumer can complete the task without any assistance.
2. **Verbal prompts** means that the consumer needs verbal prompting from the staff in order to complete the task.
3. **Gestural prompts** means that the consumer needs gestural (or a model) prompting from the staff in order to complete the task.
4. **Physical prompts** means that the consumer needs physical prompting from the staff in order to complete the task.
5. **Unable to perform** means that the consumer cannot perform the task.

When you check off an unusual answer, it may help to specify your rationale in the comments section.

Comments: _____

_____

_____

_____

_____

Signature Title Date

RN 3/30/05

Annual ~~Quarter~~

Consumer's Name Valarie YOUNG Date 3/30/05

Clinic	Date	Outcome
Audiology		
Hematology	3/30/05	LAB Work done.
ENT		
GYN	1/7/05	Attended GYN clinic.
Dental		
Dermatology		
Opthalmology		
Podiatry	1/28/05	Seen by Podiatrist - Nail debridement was done.
Neurology		
Psychiatry		
Chest X-ray		
EKG		NONE
Laboratory		
Other		
Other		

Nurse Signature

Date 3/30/05

BDC-1-NS-MED
REV 10/03

Please formulate RN Care for all areas where a need is indicated including personal hygiene.

Needs	RN Care Plan
To Maintain good oral Hygeind.	To make sure client keeps all dental clinic appointments as scheduled. To check and inform MD of unhealthy condition of gums/teeth.
Monitor for Constipation.	To check with staff on regular basis for BM. To inform MD if any distress noted or no BM in 2 days. Encourage extra fluids as tolerated
Monthly Weight.	To keep accurate record of monthly weight. To make sure consumer gets his/her prescribed diet as ordered by MD.

Agt Risa
Signature of Nurse Completing Assessment

3/30/05
Date

Signature of Nurse Reviewing Assessment (If Applicable)

Date

BDC-1-NS-MED
REV 10/03

4

Quarter

Consumer's Name _____ Date _____

Clinic	*Date*	*Outcome*
Audiology		
Hematology		
ENT		
GYN		
Dental		
Dermatology		
Opthalmology		
Podiatry		
Neurology		
Psychiatry		
Chest X-ray		
EKG		
Laboratory		
Other		
Other		

_____ _____

Nurse Signature Date

Brooklyn Developmental Disabilities Service Office

NUTRITIONAL ASSESSMENT

Consumer Name:Valerie Young C#:090-0032 Date:4.13.05
Wing:314 Program:B5 R01 Date of Birth:8.6.55 Sex: F X M____
Medical Diagnosis: Profound M/R, Seizure Disorder, Behavior Disorder, Schizophrenia affective
Diet: Ground Hical Hifiber, Prune Juice 8oz W/Brk. & Dinner, 2Tbs Bran W/brk. Extra Fluids.
Supplement: None

Physical Data:
Height:5ft.4 ½ in.
Body Frame: Small ____ Medium _X_ Large _____
Weight: Current.Mar. 148 lbs
Previous Annual:April 04, 147.81lbs
Desired Body Weight Range:125–135 lbs

Activity Level:
Sedentary
Moderate X
Vigorous

Should Consumer Increase activity level? Y
Explain: Consumer is unable to perform vigorous activities. However, should be encouraged to participate in simple low aerobic exercises on the wing.

Medication/ Nutrient – Drug Interaction:
Inderal----Constipation, Diarrhea,
Zyprexa---Hi Wt/Lo Wt. Hi appetite,Hi thrist, Drymouth
Topamax----Hi Wt/Lo wt. Hi Appetite, Anorexia,Constipation
Klonopin------Anorexia,Hi/Lo wt.,Hi Thirst,constipation,Nausea,Diarrhea
Tegretol-----Anorexia,Drymouth,Diarrhea,Constipation
Remeron----Hiappetite,Hi Wt. Hi thirst,Anorexia
Prevacid
Colace
Metamucil
Feet enema

Laboratory Data:

Factors Affecting Food Intake:

Appetite:	Is good
Chewing/Swallowing Ability:	Chews inadequately. Swallows W/out problems
Dining Skills:	Can feed herself. At times needs assistance
Dentition:	Has missing teeth
Food Intolerance:	None
Food Dislikes:	None

Nutritional Health Concerns:
HX. Chronic Constipation
Hx. Hemmorrhoids

Nutrition Risk Level:
Low Risk:
Moderate Risk: X
High Risk:

Assessments (Include current behavior, past responses, dietary intervention, counseling efforts, etc.)

This is a 49 Y.O Female who is 5ft. 4 ½ ins tall with Medium body frame, and who functions within the range of Profound M/R. Ms Young's wt fluctuated bt. 142–148 lbs over the year. Except for 8/04 where she showed significant wt lost of 12 ½ lbs that was possible scale error. Her wt as of Mar. 148 lbs is a slight gain over the year. It is noted that medications Zyprexa, Topamax, Klonopin and Remeron contributes to Hi/Lo wt. At present receiving a Hical diet. Her Supplement Ensure 8oz O.D was D/c because of the wt gain. Her wt as of Mar. is above her DBW (125–135 lbs) by 13lbs. Not significant at this time since she becomes hyper at times and has tendency to lose wt. Will monitor closely for any changes. Has a good appetite. Completes all of her meals. Can feed herself with some spillage. However, if she refuses to feed herself she is fed by staff. Drinks from a regular cup. Receives a Built Up Handled Teflon coated Tablespoon (BHTcs), Food Guard (FG)) and Non Slip Pad (NSP) to help facilitate feeding. Has missing teeth and chews inadequately. Therefore, receives a Ground diet to prevent choking. Has a Hx. of chronic constipation and Hemnorrhoids. She is receiving medication and Hifiber diet, Prune Juice 8oz with Brk. and Dinner, 2Tbs Bran, Pureed bread also has added fiber. Fresh salad W/lunch. In addition to regular meal pattern, extra fluids are given at snack time Am and Pm. Was hospitalized 12.1.04—12.13.04. Family is very much involved in her plan of care. Fu for current lab Vals.

Strengths	Needs
Can feed herself with spoon	To lose ½--1lb a month
Can drink from a cup	To improve dining room skills
She has a good appetite	To give assistance with feeding as needed

Recommendations:
- Fu monthly wt closely for any changes
- Fu for current Lab Vals.
- Monitor for constipation
- Encourage fluid intake
- Continue diet.

Clinician's Signature	Title	4.1.05 Evaluation Date
Marion Beamish	RD/LD	

Brooklyn Developmental Disabilities Service Office(PRIVATE)

PROGRAM ANNUAL SUMMARY

Client's Name: Valerie Young C#: 090-0032 Annual Date:4-13-05

IV. SENSORY MOTOR DEVELOPMENT (Part 1)

(please note: In all four domains of this evaluation, "N/A" in this checklist denotes that the skill is not in her potential at this time. The text of each domain reflects a summary of Valerie's skills. See classroom checklist for further skill-description).

A. Motor Dexterity Skills for Task Completion: Valerie has full range of motion in her upper and lower extremities. She is ambulatory. At this time she demonstrates some functional use of both hands. She inconsistently demonstrates a strong palmer or pincer grasp. She seems to be able to stretch her arms and extend them. She demonstrates poor eye/hand coordination. She can transfer objects from hand to hand and from container. She climbs stairs with supervision. She is right dominant. She can reach toward and touch objects and occasionally tries to grasp and release them.

B. Sensory skills: She appears to sometimes react normally to visual stimuli. She is able to look briefly at an object and make good eye contact. Tactile: She tolerates appropriate touch from familiar people, and inconsistently from unfamiliar people. She does not react to different textures, nor does she reach for or explore textures. Auditory: She turns her head briefly toward sounds. Gustatory: She responds differently to food textures, and seems to prefer small smooth pieces of food. She does not react differently to various taste. Olfactory: Valerie reacts to the scent of her food by turning her head and making faces. At times she might look toward the source of smells and will move toward the sight of foods.

Clinician's Signature	Title	Eval Date
Teresa Watson	Rehab Asst	4.5.05

CP

IV. SENSORY MOTOR DEVELOPMENT (Part 1)

STRENGTHS

Valerie can: -demonstrate full range of motion in upper and lower extremities
-walk
-make good eye contact
-look briefly at an objects
-tolerates appropriate touch from familiar people
-turn her head briefly toward sounds
-respond differently to food textures

(See classroom checklist for comprehensive description)

SUMMARY OF CURRENT GOALS

Goal #2 During program, Valerie will attend to sensory stimulation activities for ~~four~~ (6) minutes w/pp at wrist.

PROGRESS MADE

Goal #2-started 1-1-05
Currently on SRO B

REGRESSION OBSERVED/DOCUMENTED

slow progressions due to several previous hospitalizations but, at this time is showing a little progress

FOCUS FOR FUTURE NEEDS

Upon attainment of goal #2 Valerie will attend to sensory stimulation activities for ~~six~~ (7) minutes with physical prompts at the wrist.

BROOKLYN DEVELOPMENTAL DISABILITIES SERVICE OFFICE

RECREATIONAL ANNUAL SUMMARY

Consumer's Name: Valerie Young C#:090-0032 Annual Date: 4-13-05

IV. SENSORY MOTOR DEVELOPMENT (Part 2)

A. Mobility: Valerie is fully ambulatory & has good ROM in her extremities. Ms. Young requires close supervision when transporting to & from facility social events, held in the gym. Valerie exhibits frequent non-compliant behaviors.

1. Exercise Program: Valerie is not involved in a structured exercise program. She is encouraged to participate with her peers, in simple body movement acts: simple simon, gross motor, dancing & hand shaking.

2. Strength and Endurance: Valerie has a short attention/concentration span. She continues to require close supervision/assistance, during all sensory motor acts. Valerie does become agitated & non-compliant frequently, requiring verbal redirection & calming down time.

3. Physical Limitations: Valerie has no apparent major physical limitations.

B. Gross Motor: Valerie has good gross motor skills. She is capable of participating in: adaptive bowling, foam bowling toss, target ball toss, simple simon & ball passing with physical assistance/guidance. Ms. Young frequently walks away from her group, requiring verbal redirection to return to her activity.

Fine Motor: Valerie has fair fine motor skills. She continues to manipulate & transfer, objects of choice. Valerie is capable of participating in bingo & lotto, with constant supervision, when cooperative. She is capable of handing staff supplies haphazardly, without prompting. Valerie uses both pincer/palmer grasp functionally.

D.

Strengths	Needs
Fully ambulatory	maintain her level of gross/fine motor skills.
Good ROM in her extremities.	
Participates in most acts with close supervision.	
Good gross motor skills.	
Fair fine motor skills.	
Capable of assisting staff, when cooperative.	

E. Assessment: Valerie is alert/aware of her surroundings, staff, peers & mother. She becomes agitated & uncooperative frequently, requiring verbal redirection & calming down time. Valerie requires close supervision/assistance, before most involvement will occur in group sensory motor acts.

F. Recommendations: Valerie will continue to be encouraged to participate in group sensory motor acts. She will receive all the necessary verbal/physical assistance, required for active involvement to occur.

Clinician's Signature Title 3-10-05 Eval. Date

COGNITIVE DEVELOPMENT

Brooklyn Developmental Disabilities Service Office

PROGRAM ANNUAL SUMMARY

Client's Name: Valerie Young C#: 0900032 Annual Date: 5/13/05

V. COGNITIVE DEVELOPMENT

A. Cognitive Skills:

1. Awareness Skills: Valerie will respond to her name by turning her head. At this time she will show a positive response when looking at herself in a mirror. She also does not point to body parts. She can identify a few common objects and their uses. She can locate areas in the living and program area when offered supervision and physical guidance.

2. Attention Span Skills: Valerie is being encouraged to participate in the pre-attending skills of sensory stimulation. Further development of her attending skills are depending on pre-requisite sensory skills.

3. Visual Auditory Memory Skills: Valerie is able to recognize some locations with supervision and physical guidance. Valerie is able to answer the question "Is ma here" by stating "Ma not here, she sick"(a pre-requisite for retelling events, and imitating sounds, hand and facial movements.) At this time, she does not demonstrate any skills in recognizing her own possessions and in looking for partially or totally hidden objects.

4. Concept Developmental Skills: Although she is not demonstrating these skills of matching and sorting she can occasionally reach toward and look at objects during her sensory goal implementation. Valerie is able to ask for her mother several times a week although she does not specify information about days of the week, months, holidays, seasons, weather.

5. Awareness of Cause and Effect: At this point Valerie is showing some awareness of cause effect by turning on/off a light switch inconsistently.

COGNITIVE DEVELOPMENT

B. Functional Academics:

1. Reading: Valerie briefly demonstrates a willingness to look at the pictures in books or a magazine that has a colorful cover when someone else is holding the book or magazine and turning the pages. (This brief interest can be a pre-requisite for further reading skills, i.e. letter word and sign recognition)

2. Spelling: Valerie has the ability to speak in short sentences inconsistently, (a pre-requisite skill for saying what sounds a specific letter make.)

3. Writing: Even though Valerie does not trace or write, she has the occasional ability to reach toward objects and look briefly at pictures.

4. Counting/Computations: At this time, Valerie does not demonstrate the cognitive ability to identify numerals and or count objects.

5. Practical Math:
   a. Time: At this time, Valerie does not appear to have the cognitive ability to acquire any skills relative to time-telling, (second, minute , hour, day, week, month, year).

   b. Money: Valerie is encouraged to participate in a purchase.

   c. Weights: At this time, Valerie does not appear to have the cognitive ability to acquire any skills relative to weights and measurements (more, less, equal) liquid measurements, etc.

6. Problem Solving: Valerie will navigate herself around obstacles to get to desired destination.

Teresa Sotsen Rehab Asst 4-6-05

Clinician's Signature Title Eval Date

V. COGNITIVE DEVELOPMENT

STRENGTHS

Valerie :-responds to her name by turning her head
-locates areas in her living and program areas when given supervision and physical guidance
-is able to answer the question regarding her mother being here
-likes to look at the pictures in books briefly
-will navigate herself around obstacles to get to desired destination
-can identify a few common objects and know their usage
-shows a positive response when looking at herself in a mirror

(See classroom checklist for comprehensive description)

SUMMARY OF CURRENT GOALS

Need: To further develop pre-attending skills
Goal #2 During program, Valerie will attend to sensory stimulation activities for 6 minutes w/pp

NEED: To develop money skills
Goal # -After glancing at the chosen item, Valerie will participate in its purchase w/pp at the hand

PROGRESS MADE

Goal #2-started 1-01-05
Valerie is currently on SRO B

Goal # started 11-12-03
SRO B attained 5-1-04
SRO C attained 3-31-05

COGNITIVE DEVELOPMENT

REGRESSION OBSERVED/DOCUMENTED

Slow progression due to several hospitalizations. At this time is showing some improvement.

FOCUS FOR FUTURE

G-2-Valerie will attend to sensory stimulation activities for 7 minutes w/pp at the wrist.

G- -After glancing at the chosen item, Valerie will participate in its purchase given gestural prompts.

Brooklyn Developmental Disabilities Service Office

SOCIAL SERVICE ANNUAL SUMMARY

Consumer's Name: *Valerie Young* ***C#:*** *090-0032* ***Annual Date:*** *4/13/05*

VI. SOCIAL DEVELOPMENT (Part 1)

A. ***Interpersonal Skills (How does consumer interact with others):***
Ms. Young is aware of her environment. She is able to follow simple directions, recognizes family members and familiar others. She will turn her head in the direction of the speaker and maintain eye contact when her name is called. She needs total staff assistance and supervision with ADL skills.

B. ***Social Skills (Ability to recognize social cues, appropriateness of social behavior etc.):***
Ms. Young does not exhibit and maladaptive behaviors at this time. She has a low level of frustration tolerance and is on a behavioral plan for aggression, disruption and non-compliance. Ms.Young is able to express her wants and needs through gestures and verbally.

1. ***Living Environment:***
Ms. Young was observed on the wing on 4/6/05. She was able to feed herself breakfast.

2. ***Program Area:***
Ms. Young was observed in program on 4/6/05. She is able to attend to task with physical and verbal prompts.

3. ***Social Recreational Activities:***
Ms. Young enjoys going on trips in the community and the attention of others. She is encouraged to participate in other activities such as music appreciation, coloring and TV viewing.

4. ***With Family (Describe relationship with family):***
Mrs. Viola Young (mother) is very involved in Valerie's welfare. She visits very often.

C. ***Summary:***
Ms. Young is a 49-year-old African American female who functions within the profound range of mental retardation. She has a diagnosis of schizoaffective, history of seizure disorder and chronic constipation. She has a low level of frustration tolerance and is on a behavioral plan for aggression, disruption and non-compliance. She is able to express her wants and needs verbally and through gestures.

D. ***Recommendations:***
Ms. Young would benefit from in a structured group home for the developmentally disabled with challenging behaviors.

Clinician's Signature	*Title*	*Eval. Date*
S. [illegible]	SWA II	4-7-05

BROOKLYN DEVELOPMENTAL DISABILITIES SERVICE OFFICE

RECREATIONAL ANNUAL SUMMARY

Consumer's Name: Valerie Young C#: 090-0032 Annual Date: 4-13-05

VI. SOCIAL DEVELOPMENT (Part 2)

A. Social and Environmental Awareness: Valerie is verbal & speaks in 1-4 words. She understands & is capable of following simple directions/requests. Ms. Young is alert & aware of her surroundings, staff, peers & mother. Valerie requires close supervision during all socialization acts, due to her uncooperative behaviors(yelling, screaming & annoying others). She is capable of laughing/smiling at the appropriate times.

B. Recreation Preference: family visits, walking around her unit freely(supervised), music & tossing acts.

C. Social Amenities/Social Appropriateness: Valerie requires close supervision/guidance, during all social events, due to her frequent uncooperative behaviors. She continues to become mischievous and annoying to others frequently.

D. Community Inclusion/Leisure Trips (include highlights of specific trips and consumer's response to community contacts, etc.): Past yr: class outings(head-up T. Dotson)-Universoul Circus, Pumpkin Patch BrooklynTerminal Market, Canarsie Pier, Coney Island(boardwalk), Prospect Park, GreenAcres Mall & Aquduct Flea Market. Rec: Sheepshead Bay, Canarsie Pier, Kings Plaza & Gateway Malls. Valerie also was hospitalized during the year, had clinic appoints & regular family visits.

Strengths	Needs
Speaks in 1-4 words	increase her attention span during socialization acts.
Understands & is capable of following simple directions.	
Aware of her surroundings, staff, peers & mother.	
Enjoys family visits, music, walking & tossing activities.	
Capable of laughing/smiling at appropriate times.	
Capable of participating on community outings.	

F. Recommendations: Ms. Young will continue to be encouraged to participate with others during socialization/recreation acts. She will receive verbal praise when she participates without exhibiting non-compliant behaviors.

Clinician's Signature Title 3-10-05 Eval. Date

Brooklyn Developmental Disabilities Service Office

PSYCHOLOGICAL ASSESSMENT

Consumer's Name: VALERIE YOUNG **C#:** 090-0032 **Annual Date:** 4-13-05

AFFECTIVE EMOTIONAL DEVELOPMENT

I. BACKGROUND INFORMATION – (Discuss previous test results, psychiatric history, placement history, previous involvement with the criminal justice system)

MS. YOUNG DOES NOT HAVE ANY HISTORY WITH THE CRIMINAL JUSTICE SYSTEM. SHE CAME FROM HOME TO BDC ON 9-26-90. IN 1996 SHE WAS GIVEN THE WIS R AND ATTINED AN I.Q. OF BELOW 20. SHE WAS ALSO GIVEN THE VINELAND ADAPTIVE BEHAVIOR SCALE. SHE ATTAINED AN AGE EQUIVALENT OF ONE YEAR AND NINE MONTHS.. THESE SCORES ARE CONSISTANT WITH PREVIOUS SCORES AND INDICATES FUNCTIONING ADAPTIVELY AT AND INTELLECTUALLY AT THE PROFOUND RANGE.

II. CURRENT TEST RESULTS:

Test Utilized WAIS R

Date Administered; 1996

IQ Score BELOW 20

Adaptive/Social Functioning: profound

Scale Used VINELAND ADAPTIVE BEHAVIOR SCALE

Date Administered 4-05

Adaptive Composite Score: 1 YEAR AND 9 MONTHS

MR Diagnosis PROFOUND

Comments:
NONE

III. BEHAVIOR MANGEMENT REVIEWS:

Review Date 1-6-05,11-7-04, 9-2-04, 7-22-04, 5-17-04, 4-15-04, and 3-4-04.

Current Medication:

Inderal, remeron, and zyprexa.

A. Approved Range:

Remeron 45 m.g., inderal 140-280, and zyprexa 40 m.g.

B. Restrictive Techniques:

	Yes	No	Type
1. Adaptive Equipment	___	_X__	
2. Physical Restraints	___	_X__	
3. Time Out	___	_X__	

C. Risk Management/Forensic Issues

NONE

E. Individual is able/not able to provide informed consent for treatment based on understanding of risks and benefits of their treatment plan.

MS. YOUNG IS UNABLE TO GIVE INFORMED CONSENT FOR HER SERVICES DUE TO HER NOT UNDERSTANDING THE RISKS AND/OR BENEFITS THAT ARE INVOLVED.

IV. A. Describe relationships with peers and staff in individual and group settings.

MS. YOUNG WILL AT TIMES INITIATE INTERACTION WITH HER PEERS OR WITH STAFF. SHE WOULD SAY ONE OR TWO WORDS AND POINT WHILE MAKING EYE CONTACT. SHE WOULD PARTICIPATE IN SOCIAL ACTIVITIES WITH VERBAL AND PHYSICAL PROMPTS. SHE MAY ENJOY ONE TO ONE ATTENTION WHILE OTHER TIMES SHE PREFERS TO BE ALONE.

B. Sexuality Assessment:

	Yes	No
1. Knowledge of need for privacy.	____	__X__
2. Ability to say no to unwanted sexual advances.	____	__X__
3. Understanding of social/sexual relationships.	____	__X__
4. Understanding of risks and benefits of contraception.	____	__X__
5. Understanding of sexually transmitted diseases.	____	__X__
	____	__X__
6. Ability to give consent for sexual activity	____	__X__

7. Describe any inappropriate sexual behavior

NONE

V. COGNITIVE AWARENESS:

	Yes	No
A. Ability to maintain a key	____	_X___
1. Able to use key	____	_X___

2. Able to maintain key in possession.	____	__X__
Able to maintain personal possessions i.e		

B. Voting

1. Consumer is able to vote.	____	__X__
2. Is interested in voting	____	__X__
3 Needs training.	____	__X__
4. Would not benefit from training.	____	__X__

VI. EMOTIONAL DEVELOPMENT::

A. Affective Tone:

HER AFFECT IS FLAT WHILE APPROPRIATE WITH THE SITUATION. HER INSIGHTS AND JUDGEMENT REMAINS LIMITED.

B. Symptoms of Disturbance:

MS. YOUNG HAS A DIAGNOSIS OF SCHIZOAFFECTED AND PROFOUND M.R. SHE HAS NOT EXPERIENCED ANY MOOD SWINGS OVER THE PAST YEAR. THERE HAS BEEN TIMES WHEN SHE APPEARS TO BE HAPPY AND ALERT AND OTHER TIMES SHE APPEARS TO BE AGITATED. THERE HAS BEEN REPORTS OF HER HALLUCINATING AND WAS SEEN BY THE PSYCHIATRIST.SHE EATS WELL BUT WHEN AGITATED SHE REQUIRES PROMPTING TO DO SO. WHEN CALM SHE SLEEPS WELL BUT WHEN AGITATED SHE WOULD STAY UP THE NIGHT. SHE WAS HOSPITALIZED AT A PSYCHIATRIC HOSPITAL DUE TO UNMANAGEABILITY WITHIN THE PAST YEAR BUT IS CURRENTLY STABLE.

C. Impulse Control:

SHE HAS GOOD IMPULSE CONTROL BUT MY AT TIMES EXHIBIT AGGRESSION, DISRUPTION AND NON-COMPLIANCE.

D. Coping Strategies:

CURRENTLY SHE WILL NOT BENEFIT FROM COUNSELING. BUT IS GIVEN VERBAL PROMPTING WHEN WARRENTED.

E. Motivators(Reinforcers):

VERBAL, PHYSICAL PRAISE, AND SOME EDIBLES.

VII. MALADAPTIVE BEHAVIORS:

Describe any maladaptive behaviors including:

A. (a) frequency (b) intensity (c) duration

MS. YOUNG EXHIBITS AGGRESSION, DISRUPTION, AND NON-COM PLIANCE. THE FREQUENCY, INTENSITY AND DURATION ARE CURRENTLY LOW. HOWEVER, SHE WAS HOSDPITALIZED TO A PSYCHIATRIC CENTER DUE TO UNMANAGEABILITY OF BIZZARE BEHAVIORS.

B. (a) Antecedents/precipitants (b) function (c)outcome (d) stress management..

CURRENTLY THE ANTECEDENT FOR THESE BEHAVIOR IS NON-COMPLIANCE. THE FUNCTIONS ARE FRUSTRATION, DISCOMFORT, AND NON-COMPLIANCE. THESE BEHVIORS CAN BE SEVERE AND HAS LED TO OTHER BEHAVIORS WHICH HAS RESULTED IN PSYCIIIATRIC HOSPITALIZATIONS. OVERALL THEY ARE EASILY REDIRECTED. DUE TO HER LEVEL OF FUNCTIONING AND LIMITED COGNITIVE SKILLS SHE WILL NOT BENEFIT FROM STRESS MANAGEMENT.

VIII. INTERVENTION: (A) Describe interventions (B) progress and fluctuations in behavior over the past year (C) include any major events occurring during the past year that influenced consumer's progress in treatment.

Behavior goals -

MS. YOUNG IS ON THREE BEHAVIOR GOALS WIIICH ARE NON-COMPLIANCE, AGGRESSION AND DISRUPTION.THE INTERVENTIONS FOR THESE BEHAVIORS ARE VERBAL, PHYSICAL, AND REMOVAL OF AREA. HER BEHAVIORS HAS FLUCTUATED OVER THE PAST YEAR. SHE IS CURRENTLY MAKING PROGRESS.

Contingency Plans -

NONE

Counseling -

NONE AT THIS TIME. SHE WILL NOT BENEFIT FROM COUNSELLING DUE TO HER LEVEL OF FUNCTIONING.

IX. (A) Describe any reduction in intrusive/restrictive techniques utilized

PSYCHOTROPIC MEDICATION HAS BEEN REDUCED AND SEVERAL CHANGES WERE MADE DUE TO INSTABILITY.

X.

(B) Describe criteria for reducing utilization of restrictive techniques.

(C) If no reduction, explain why.

HER BEHAVIOR FLUCTUATES FROM TIME TO TIME.

XI. CLINICAL OBSERVATIONS:

A. Observations – Date, time, place and activity. Describe attention span, awareness of environment, interaction with others, maladaptive behaviors, affect, psychiatric symptomatology.

MS. YOUNG IS OBSERVED SEVERAL TIMES A WEEK ON THE WING AND IN THE PROGRAM AREA. ON 4-1-05 SHE WAS OBSERVED FOR THE PURPOSE OF THIS EVALUATION. IN THE MORNING DURING FEEDING SHE RESPONDED WELL TO STAFF, FOLLOWED DIRECTIONS WITH PROMPTS, AND WAS AWARE OF HER SURROUNDINGS. IN PROGRAM SHE ALSO FOLLOWED SIMPLE DIRECTIONS FROM STAFF AND COMPLETED ALL TASKS THAT WERE REQUESTED OF HER. HER ATTENTION SPAN WAS LIMITED AND HER AFFECT WAS FLAT AND NO PSYCHIATRIC SYMPTOMATOLOGY.

XI.

STRENGTHS	NEEDS
RESPONDS TO NAME	TO ELIMINATE NON COMPLIANCE
RESPONDS TO AFFECTION	TO ELIMINATE DISRUPTION
FOLLOWS SIMPLE DIRECTIONS WITH PROMPTS.	TO ELIMINATE AGGRESSION
IS AWARE OF HER SURROUNDINGS	
DOES NOT EXHIBIT ANY INAPPROPRIATE SEXUAL BEHAVIORS.	

XII. RECOMMENDATIONS:

IT IS RECOMMENDED THAT MS. YOUNG CONTINUES WITH HER CURRENT SERVICES.

K. VILLANUEVA	PSYCH ASST. 111	4-1-05
Clinician's Signature	Title	Evaluation Date

K. V Villanueva

Brooklyn Developmental Disabilities Service Office

ANNUAL PSYCHIATRIC ASSESSMENT

CONSUMER'S NAME Young (Last) Valerie (First) (M.I.) C# D.O.B. 8-6-55

ALERTS: List current risk factors, including danger to self/others (specific degree of risk and targets) physical health conditions/needs, allergies, CPL status, etc.

Physical aggression
Psychosis
Allergy Navane, Haldol and Depakote

COURSE OF TREATMENT/OUTCOME OVER THE PAST YEAR (Summarize consults over the course of the year, any significant issues addressed, list any psychiatric hospitalizations or ER referrals)

49 year old African American female has profound mental retardation, Epilepsy and Schizoaffective dis. / Intermittent explosive dis / Impulse Control dis. Includes unprovoked aggression hits bits kicks other clients and staff. associated with excessive agitation, property destruction, disruptions; self abusive behavior throws self on the floor, hits herself. She is at times non compliant refuses to follow staff directives. She had many psychiatric admissions and ER visits, last admission at KCHC psych on EOB Dec 13, 04 She is currently treated with Antiepileptic drugs (AEDs) and neuroleptics and has made great improvement.

MENTAL STATUS

A. APPEARANCE:
looks older than stated age, wears pink jogging suit, medium height + build, ambulatory, no apparent distress, neat + clean

B. ATTITUDE: Note cooperation, guardedness, avoidance
uncooperative

C. BEHAVIOR: Note psychomotor activity, abnormal movements
normal psychomotor activity

D. SPEECH: Note rate and abnormalities
non verbal

E. THOUGHT PROCESSES: Note logic and organization; presence of circumstantial, tangential, flight of ideas, loosening of associations, etc. Describe in consumer – specific terms.
N/A

F. THOUGHT CONTENT: Note delusions, ideas of reference; describe in terms specific to this consumer.
N/A

G. PERCEPTUAL DISORDERS: Note hallucinations; describe in terms specific to this consumer.
good eye contact She does not appear to be responding to internal stimuli.

H. MOOD/AFFECT: Note depression, elation/ appropriateness / mood swings
mood neutral
affect flat

I. **IMPULSE CONTROL: Note aggressive, hostile, sexual impulses and ability to control them.**

Good impulse Control
Remains calm no aggressive hostile behavior observed

J. **SUICIDAL AND/OR HOMICIDAL BEHAVIOR / IDEATION:**
Note in terms specific to this consumer . Assess degree of intent.

No Suicidal / Homicidal behavior observed or reported

COGNITIVE FUNCTIONING EXAMINATION.
(Describe all tests used to make the following interpretations)

1. **Sensorioum/Level of Consciousness: Indicate whether awake, responsive, lethargic, fluctuating.**

Alert Awake

2. **Orientation: Indicate time, season, day, month, year, next holiday; place, type, exact name: person**

oriented to person

3. **Memory - Attention: Immediate recall, digit span, serial numbers.**

un communicative Cognitive defict (++)

4. **Recent Memory: (Personal – Non-personal)**

limited

5. **Ability to abstract and generalize: Include proverbs and similarities**

no abstracting ability

6. **Insight/Judgment: Include consumer awareness of own mental illness and understanding of consequences . Describe in specific terms.**

chronic impairment of both insight + judgment

Current Medication/List Current Medication:

Klonopin 0.5mg/d
Zyprexa 40mg/d
Remeron 45mg/d
Inderal 240 mg/d
Tegretol 1200mg/d
Tofamax 200mg/d
Behavior and Seizure Medicat

Reason for Medication: Schizoaffective dis. / Intermittent explosive dis. physical aggression - property destruction - self injury

Note any reduction/changes in medication over the last year:

Clozaril d/c'd and replaced w Zyprexa. Klonopin added to the regimen

If no reduction, give clinical justification:

Decompensation

Potential Medication Side Effects:

EPS - Drowsiness - Hypotension - Wt gain Metabolic disturbances.

Side Effects Observed:

none

Medication Interactions /Criteria for reduction/Change:

If V.Y remains stable for 6-7 mos will reduce Zyprexa to 35 mg/d and will eliminate Klonopin.

CURRENT DIAGNOSIS

Axis I: Schizoaffective dis. / Intermittent explosive dis.

Psychiatrist Signature

4-4-05
Date

Serge L. Delbrune
Print Name

Brooklyn Developmental Disabilities Service Office

PROGRAM ANNUAL SUMMARY

Client's Name: Valerie Young C#: 0900032 Annual Date:4/13/05

IX. ADAPTIVE/INDEPENDENT LIVING SKILLS

A. Activities of Daily Living:

1. Dining: Even though Valerie does not consistently hold her spoon, she has the occasional ability to reach toward objects, and she seems to enjoy most of her foods (pre-requisite skills for further dining tasks (i.e. finger feeding, pouring, using napkin, utensils, social dining). At this time she is holding her cup while drinking.

2. Toileting: Valerie does not participate in pre or post toileting skills however, she is able to speak in short sentences inconsistently (a pre-requisite for indicating toilet use) She has the occasional ability to reach toward objects (a pre-requisite for flushing the toilet)

3. Dressing/Undressing: Valerie moves limbs when being dressed and undressed.

4. Personal Hygiene: At times Valerie will briefly participate in wetting and lathering her hands with physical prompts. She is currently being encourage to dry her hands by reaching for the presented paper towel.

5. Grooming: Valerie occasionally enjoys getting her hair braided, she also looks briefly at the person offering compliments on her hair. For the most part she will always require staff assistance in monitoring her appearance.

6. Oral Hygiene: Valerie is currently on a toothbrushing goal to improve her oral hygiene skills.

ADAPTIVE/INDEPENDENT LIVING SKILLS

B. Independent Living:

1. Domestic Skills: Based on her current level of cognitive and motoric functioning at this time, Valerie does not demonstrate skills in meal preparation, household duties, clothing care, pouring, opening simple packages, etc.

2. Community Skills: She can travel in a van, a car, or can ride on elevator. She will always require close supervision.

3. Use of Resources: At this time, Valerie does not appear to have the cognitive ability of acquiring any skills relative to community-awareness (locating stores, utilizing public services.

4. Financial Management: At this time, Valerie does not appear to have the cognitive ability of acquiring any skills relative to financial management (budgeting/saving).

5. Ability to Give Personal Information: Currently Valerie can say "Ma here", "Ma sick", "I want to go home". Presently Valerie does not provide any additional personal information. Further verbalizations will continue to be encouraged.

Clinician's Signature	Title	Eval Date
Teresa Sotsom	Rehab Asst	4-7-05

IX. ADAPTIVE/INDEPENDENT LIVING SKILLS

STRENGTHS

Valerie: -Can feed herself with a spoon inconsistently
-can pick up/hold/and drink from a cup
-can ride in a car, van and on a elevator
-(As far as the ability to give personal information) can say "Ma here", "Ma sick", "I want to go home".

(See classroom checklist for comprehensive description)

SUMMARY OF CURRENT GOALS

G-5 (To improve personal hygiene) After washing her hands, Valerie will reach for the towel presented to her given physical prompts at the elbow.

G-9 (To develop dining skills) during meals, Valerie will hold her spoon through ~~four~~ (6) spoonfuls of food given pp at wrist.

G- (To improve oral hygiene skills) during ADL, Valerie will brush all of her teeth given hand/hand assistance.

PROGRESS MADE

G-#5-started 4-1-05

G-#9-started 12-1-04 (currently on SRO B)

G-# -started 4-21-04
SRO B attained 12-31-04
SRO C attained 3-31-05
Currently on SRO D

REGRESSION OBSERVED/DOCUMENTED

Slow progression due to several hospitalizations

ADAPTIVE/INDEPENDENT LIVING SKILLS

FOCUS FOR FUTURE NEEDS

Upon attainment of goal #5, Will reach for paper towel presented to her when given 2 or less pp at the elbow.

Upon attainment of goal #9, Valerie will hold her spoon through (7) spoonfuls of food given pp at wrist.

Upon attainment of goal # , Valerie will brush her teeth given pp at the wrist.

NEEDS

3-1

Brooklyn Developmental Disabilities Service Office

SPEECH/LANGUAGE PATHOLOGY ANNUAL SUMMARY

Client's Name: Valerie Young C#: 090-0032 Annual Date: 04/13/05

VIII. COMMUNICATION/AUDITORY DEVELOPMENT

A. ORAL PERIPHERAL EXAMINATION: Ms. Young was assessed for limitations of the oral mechanism. Results: Articulatory structures appear adequate for speech purposes and vegetative functions. Note: Ms. Young maintains an open mouth position at rest resulting in consistent drooling. She receives a ground diet texture that she is better able to handle. Currently, Ms. Young is on a choking precaution for aspiration. She must be monitored during meals. Ms. Young uses a built-up-handle Teflon coated spoon, food guard and a non-slip pad.

B. FUNCTIONAL HEARING ABILITY: Available audiological information for Ms. Young indicates: Hearing is within normal limits for conversational speech bilaterally.

C. TESTING PROCEDURES: Speech and Language Annual Screening Summary, client observation and interview, staff reports.

D. RECEPTIVE LANGUAGE ABILITIES: Ms. Young's current receptive language skills include: Awareness of her environmental surroundings; recognition of and response to her name and significant others; some knowledge of common objects through appropriate manipulation. Ms. Young comprehends simple verbal directives, but at times, she requires persistent prompting to carry them out.

E. EXPRESSIVE LANGUAGE ABILITIES: Ms. Young has limited verbalization. However, she speaks in single words, short phrases and in simple sentences at times. Ms. Young will indicate wants and needs when questioned. The use of her expressions varies. Ms. Young is either asking for something, someone – or commenting on what is happening in her environment at the time. At times, her verbalizations appear out of context of the present situation. But, in these instances she may be reacting to a previous occurrence she saw taking place. The content of Ms. Young's verbalizations may be about her family, what happens on her wing or in the classroom. Her overall speech, is fairly intelligible.

F. OTHER: Profound MR

3-1

Brooklyn Developmental Disabilities Service Office

SPEECH/LANGUAGE PATHOLOGY ANNUAL SUMMARY

Client's Name: Valerie Young C#: 090-0032 Annual Date: 4/13/05

VIII. COMMUNICATION/AUDITORY DEVELOPMENT

G. STRENGTHS: Receptive/Expressive
Very aware of her environmental surroundings
Can localize to sounds and familiar voices
Recognizes and responds to her name
Appears to comprehend the function of objects common to her environment
Has some manipulative abilities for common objects
Appears to understand simple verbal directives
Recognizes her family and familiar staff
Can verbalize typical greetings, single words and simple phrases.
Will indicate a need when questioned, however, this can be inconsistent

H. NEED: To continue appropriate use of current expressive language skills via integration methods in daily program goals. The audiologist will monitor Ms. Young's hearing status.

I. CLINICAL IMPRESSIONS & RECOMMENDATIONS: Ms. Valerie Young can verbalize in single words and simple phrases. Her major use of expressive language is to indicate rejection; convey wants and needs when questioned; and to display the knowledge that her family have come to visit her. Ms. Young should be encouraged to use her expressive language whenever appropriate during her daily programming.

Hannah Blackwell — Speech Lang. Path. — 3/24/05

Clinician's Signature | Title | Eval. Date

VOCATIONAL DEVELOPMENT

Brooklyn Developmental Disabilities Service Office

PROGRAM ANNUAL SUMMARY

Client's Name: Valerie Young C#: 0900032 Annual Date:4/13/05

X. VOCATIONAL DEVELOPMENT

A. Attending Behavior: Valerie is being encouraged to participate in the pre-attending skills of sensory stimulation. Further development of her attending skills are depending on pre-requisite tasks.

B. Motivation: Valerie is briefly sometimes motivated by much verbal praises.

C. Participation: Her participation skills are currently involving 3 group activities when given verbal prompting.

D. Task Completion: She currently does not complete tasks. She is continuously verbally and physically prompted to remain on a task.

E. Punctuality: She has dc be escorted to program. She will always need total supervision to get to program and to all appointments.

F. Response to Supervision: She will follow some simple instructions with physical and verbal guidance.

G. Ability to Follow Routine: Valerie has the ability to follow some simple routines but for the most will always need physical guidance and total supervision to get her own materials and to return them back to closet.

H. Knowledge of Job Related Information: Valerie does not verbally demonstrate any knowledge concerning her classroom duties. At this time, Valerie does not appear to have the cognitive ability of acquiring skills relative to participating in the knowledge of job related information.

I. Work Skills:

1. Assembly: At this time, Valerie does not appear to have the cognitive ability of doing any assembling, (twisting, turning).

2. Packaging: At this time, Valerie does not appear to have the cognitive ability of doing any simple packaging, (opening, closing).

3. Collating: At this time, Valerie does not appear to have the cognitive ability to stack, fold or staple.

VOCATIONAL DEVELOPMENT

4. Sorting: At this time, Valerie does not appear to have the cognitive ability to sort by color, size or shape.

Clinician's Signature	Title	Eval Date
Teresa Gotson	Rehab Ass't	4-8-05

X. VOCATIONAL DEVELOPMENT

STRENGTHS

Valerie: -is sometimes briefly motivated by much verbal praises.
-is being encouraged to participate in 3 group activities given verbal prompts.
-can follow some simple directions given verbal and physical guidance.
-can follow some simple routines with physical guidance and total supervision.

(See classroom checklist for comprehensive description)

SUMMARY OF CURRENT GOALS

NEED: To improve participation in group activities
Goal #3-
During socialization, Valerie will participate in ~~two~~ (3) group activities given 2 or less verbal prompts.

PROGRESS MADE

Goal #3-started 4-1-05

REGRESSION OBSERVED/DOCUMENTED

Slow progression due to several hospitalizations

FOCUS FOR FUTURE NEEDS

Upon attainment of goal #3, Valerie will participate in three (3) group activities given an initial verbal cue.

CLIENT CASH SYSTEM

QUARTERLY REPORT BEGINNING 04/01/2005 ENDING 06/30/2005 FOR STATUS GROUP(S):

DEAD DISCHARGED INPATIENT COMM. RES. FAMILY CARE I.C.F. OTHER I R A

TABS ID	CONSEC #	CLIENT NAME LAST	FIRST	MI	UNIT#/ COM RES	STATUS	SOC SEC#	MEDICAID#
00046977	0000032	YOUNG	VALERIE		314	2	075-54-8252	BZ66389C

Expired

CLIENT CAPABLE OF HANDLING OWN FUNDS: N INTEREST EXCLUSION: N

PERIOD ENDING BALANCES:

TOTAL BALANCE	ENCUMBRANCE	BURIAL FUND	FREE BALANCE	CARE & MAINTENANCE CHARGE	C & M ENCB. BAL	NON-C&M ENCB. BAL	NON-C&M + FREE BAL.
359.13	.00	.00	359.13	927.00	.00	.00	359.13

BENEFITS:

TYPE	I.D. NUMBER	BENEFIT AMOUNT	TOTAL AMOUNT	ELIGIBLE?
SSA	237381439C1	962.00	962.00	YES
SSI	075548252	.00	.00	NO
RR		.00	.00	NO
VA		.00	.00	NO
FCSA		.00	.00	NO
OTHER		.00	.00	NO

TRAN DATE	TRAN CODE	TRAN NUM	ENC/ RES#	REF NUM	VEN CDE	RECEIPT	DIS-BURSEMENT	EN-CUMBERANCE	BURIAL FUND	FREE BALANCE	DESCRIPTION
04/01/05	A30	471	000	GOVDD		962.00				1,581.84	SOCIAL SECURITY (SS)
04/04/05	B32	472	000	C/M03				927.00+		654.84	CARE & MAINTENANCE - OMR (INPATIENT)
04/21/05	E32	473	472	30166	032		927.00	927.00-		654.84	CARE & MAINTENANCE - OMR (INPATIENT)
04/29/05	A50	474	000	INT04		.53				655.37	BANK INTEREST
05/03/05	A30	475	000	GOVDD		962.00				1,617.37	SOCIAL SECURITY (SS)
05/04/05	B32	475	000	C/M04				927.00+		690.37	CARE & MAINTENANCE - OMR (INPATIENT)
05/24/05	E32	477	476	30466	032		927.00	927.00-		690.37	CARE & MAINTENANCE - OMR (INPATIENT)
05/25/05	B44	478	000	TOUCH TOUCH				367.20+		323.17	CLOTHING - RETAIL STORE
05/31/05	A50	479	000	INT05		.58				323.75	BANK INTEREST
06/03/05	A30	480	000	GOVDD		962.00				1,285.75	SOCIAL SECURITY (SS)
06/03/05	B32	481	000	C/M05				927.00+		358.75	CARE & MAINTENANCE - OMR (INPATIENT)
06/21/05	E32	482	481	30690	032		927.00	927.00-		358.75	CARE & MAINTENANCE - OMR (INPATIENT)
06/22/05	E44	483	478	30728	785		367.20	367.20-		358.75	CLOTHING - RETAIL STORE
06/30/05	A50	484	000	INT06		.38				359.13	BANK INTEREST

Young 7679

Brooklyn Developmental Disabilities Service Office

SOCIAL SERVICE ANNUAL SUMMARY

Consumer's Name: Valerie Young | C#: 090-0032 | Annual Date: 4/13/05
S. S. #: 075-54-8252 | Medicaid #: BZ66389C | D. O. B.:8/6/55
D. O. A: 9/26/90 | Medicare#: 237381439C1

I. CLIENT PROFILE

A. Description of Consumer:
Ms. Young is a 49-year- old African American female who within the profound range of mental retardation. She has a diagnosis of Schizoaffective, a history of Seizure Disorder and chronic constipation, She is 5 feet 4 ½ inches tall and weighs 133.2 lbs. She verbalizes single words and is ambulatory.

B. Legal Status: Voluntary ___ Non-Objecting _X__ 2PC___
Court Retention ___ CPL ___
If CPL, give nature of charges. Note any changes to legal status during past year.

C. Religious Preference/Activity:
Ms. Young is of the Protestant faith. She is afforded the opportunity to attend religious services of that faith at BDC.

D. Developmental History (Include age of onset):
As stated in the record, Ms Young was the result of a normal pregnancy, labor and delivery. Mrs. Young suspected developmental delay when Valerie had no speech by age two and was not toilet rained until 4 ½ years of age. Physical development appeared to be normal. Ms. Young had seizures at the age of 13, before her first menstrual period.

E. Family History:
According to the records, Ms. Young was born on 8/6/55 to Sidney Young (father) and Viola Young (mother). Mrs. Young worked for the V.A. hospital. She has since retired. Mr. Young died 10/23/03. Ms. Valerie Young is the second of 3 siblings. The oldest is a female and the youngest is a male. Both live outside the home. Ms. Young resided at home with her parents until she was admitted here at BDC.

F. Placement History:
Ms. Young attended program at AHRC between the ages of 7-21. She attended the Y.A.I .Day Treatment Program in the past. She lived at home prior to her admission to BDC.

G. Current Living Arrangement (Include wing, type of population served, private or shared room and other pertinent information:
Ms. Young resides on wing 314 bldg 3-1 with 16 other consumers. She shares a room with one other female. The population on the wing consists of females that vary from mildly to profoundly retarded

H. Funding Sources/Representative Payee/Unencumbered Funds:
Ms. Young receives S.S.I. benefits. The Director of BDC is the representative payee. As of 3/31/05, she has a free balance of $619.38.

Burial Funds/Arrangements:
There are no prearranged funeral or burial plans made by the family.

J. Personal Money Management:
Ms. Young is not capable of handling her personal finances due to her cognitive level of functioning.

Rev. 6/00

Brooklyn Developmental Disabilities Service Office

COMPREHENSIVE FUNCTIONAL ASSESSMENT
ANNUAL INDIVIDUAL PROGRAM PLAN MEETING

Client's Name: VALERIE YOUNG C#: _____ Residence: 314

Date of Program Planning: APRIL 13, 2005

INTERDISCIPLINARY TREATMENT TEAM

[signature]	Team Leader
[signature] CC 65-1	Client Coordinator
[signature]	Physician
[signature]	Nurse
[signature]	Pharmacist
[signature]	Dietician
Teresa Watson	Day Program
	Rehab. Program
	Outside Prog. Liaison
[signature]	Psychologist
[signature]	Social Worker
Karen Roberts DAT	Direct Care
	Recreation
	Physical Therapist
	Occupational Therapist
[signature] LCSW	Speech Pathologist
[signature] Hayes Lab	Other/Sign Title
	Client
	Correspondent

Parent/Correspondent was (✓) was not ( ) invited to attend the meeting.
Parent/Correspondent did ( ) did not (✓) attend the meeting.

The Client was (✓) was not ( ) at the meeting.
Client is able ( ) not able (✓) to meaningfully participate in development of the plan.

The ITT reviewed the current level of care does ( ) does not (✓) recommend a change in the residential placement at this time. Recommendation for change: /

The ITT recommended the following program placement: ATP Pavs Bldg 5

The ITT recommends integration of the following programs: Psych, Psychiatrist, SW, MD/Diet, Rec

K. ***Treatment Program Location/Transportation:***
Ms. Young attends The Activities Therapy Program in building 5 at BDC. She is escorted to and from her program daily.

L. ***Ability to Participate in Plan of Care:***
Ms. Young in not able to positively participate in her plan of care due to her cognitive level of functioning.

M. ***Informed Consent for Treatment Plan is Obtained from:***
Informed Consent is sign by Ms. Viola Young (mother).

N. ***Correspondent Involvement (Describe level of activity/participation, name, relationship, address and phone #):***
Mrs. Viola Young (mother) is the correspondent. She resides at 259 East 49th Street Brooklyn, New York 11203. Her telephone number is (718) 756-0712. She is very involved in her daughter's welfare. She visits very often and responds to telephone and written communications.

O. ***Legal Guardianship (Does consumer have a legal guardian?):*** **__YES X NO**
Describe effort to provide assistance for guardianship, advocacy, etc.)
Ms. Young is in the process of obtaining Legal Guardianship.

P. ***1. Movement/Placement Activity:***
Ms. Young was not screened for placement during the year.

2. Family/Correspondent's attitude towards placement (Objects, supports and preferences):
Ms. Young appears to support placement. She would prefer placement in Brooklyn.

Q. ***Environmental Supports for Community Placement (Include program recommendations, special needs etc.):***
Ms. Young will need the following supports for community placement: medical services Medicaid, religious services, transportation, social service, Social Security, Psychiatric/Psychological recreations/leisure services nutritional services, a Day Treatment Program.

R. ***Social Work Intervention:***

1. With Consumer:
Social Worker greeted Ms. Young. She waived her hand and said Hi.

2. With Family/Correspondent:
Social Worker maintains contact with the family via telephone calls and written communications.

Clinician's Signature | SWA III *Title* | 4-7-05 *Eval. Date*